PRINTED: 12/20/2010

DEDAR	TMENT OF HEALTH	AND HUMAN SERVICES	ا ا	K.	1/2/1	ı 1	FORM /	APPROVED 0938-0391
CENTE	RS FOR MEDICARE	& MEDICAID SERVICES	100 T	uu mele	CONSTRUCTION		CX3LDATE SU	RVEY
TATEMEN ND PLAN (T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1.	LOING			COMPLET	1 EU
		445319	B. Wit	(G			12/16	<u> </u>
	PROVIDER OR SUPPLIER			STREET	ADDRESS, CITY, S	STATE, ZIP COD	E	
		CARE & REHABILITATION CENT	ER		EMORIAL DRIVE CHESTER, TN	27398		
WILLOW			1 -	VVIIV	BBC\/DED'9	PLAN OF CORE	RECTION	(X5) COMPLETION
(X4) ID PREFIX TAG	しょうしゅうとうりにいいく	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC (DENTIFYING INFORMATION)	ID PREF TAG		(EACH CORRE	CTIVE ACTION 8	SHOULD BE	DATE
F 000	INITIAL COMMENT	S	F	l a	This Plan of on the contract of the contract o	as required	l by law. By	
F 250 SS=D	Recertification survicemplaint #27068 videficiencies were of 483.15(g)(1) PROV RELATED SOCIAL. The facility must proservices to attain or practicable physical well-being of each right of the physical well-being of each right of the physical regarding a HOSPIC twenty-one resident. The findings include Resident #1 was addiagnoses including Chronic Kidney Dise Failure, and Left About Medical record review dated September 20	ted related to the complaint. ISION OF MEDICALLY SERVICE ovide medically-related social maintain the highest mental, and psychosocial esident. IT is not met as evidenced ecord review, observation, willty falled to provide services ian's recommendation of referral for one (#1) of a reviewed. It is not met as evidenced ecord review, observation, willty falled to provide services ian's recommendation of a reviewed. It is not met as evidenced ecord review, observation, editive falled to provide services ian's recommendation. It is not met as evidenced ecord review, observation, editive falled to provide services ian's recommendation. It is not met as evidenced ecord review, observation, editive falled to provide services ian's recommendation. It is not met as evidenced ecord review, observation, editive falled to provide services ian's recommendation.	F2	250 es so ca a r a a p s f l l p h p o 2 D p	tatements, fin conclusions the alleged deficion eserves the ri- and/or regulated proceedings the	center does the Center does the Center does the Center dings, facts at form the ency. The Center of administration of Nursing esident #1 on 12/16/rs were obtained for the deficience of Nursing esident #1 on 12/16/rs were obtained for of Nursing esident #1 on 12/16/rs were obtained for of Nursing esident #1 on 12/16/rs were obtained for of Nursing esident #1 or of Nursi	s not admit on this form admit to any admit to any admit to any a, or basis for the Center enge in legal nistrative y, clusions that iciency." In and ained based tatus. In and Staff audited on 12/20/10	
	dressing, personal hy Review of the physic note/evaluation dates revealed, "Plan: 1.1							
		R/SUPPLIER REPRESENTATIVE'S SIGNA	TURE		A TITLE	·] t	اند	DATE
/ W/h	ILLAN AMOLIA	1aur				strutor		<u> </u>
deficiency	statement ending with an	asterisk (*) denotes a deficiancy which	the instit	em noitu	y de excused from a homas, the findi	conecung prov	nging it it determir e ldesolasia et ev	90 davs

I deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that it deficiency statement ending with an asterisk (*) denotes a deficiency which the institutions.) Except for nursing homes, the findings stated above are disclosable 90 days a safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the above findings and plans of correction are disclosable 14 wing the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 so following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued prarm participation.

PRINTED: 12/20/2010 FORM APPROVED OMB NO. 0938-0391 DEPARTMENT OF HEALTH AND HUMAN SERVICES

		& WEDICAID SERVICES	CV21 661	SLTIPLE CONSTRUCTION	(X3) DATE S	URVEY
STATEME AND PLAN	nt of deficiencies For correction	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BUIL) COMPLE	TÉD
		445319	B. WIN			6/2010
	PROVIDER OR SUPPLIER	CARE & REHABILITATION CE	- 1	STREET ADDRESS, CITY, STATE, ZIP CO 32 MEMORIAL DRIVE WINCHESTER, TN 37398)DE	
(X4) ID PREFIX TAG	SUMMARY STA	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SCIDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTIO) CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE	COMPLETION DATE
F 250	chronic illness, chronutrition(gender) appropriate at this p	ge 1 from renal Insufficiency, pnic infection, and poor would be very HOSPICE point if the family agrees."	F 24	identified. 3. The Director of Nurs and the Staff Developme Coordinator provided re	ing Services ent -education to	:
	from September 22 2010, revealed no deferral had been as Observation on Decrevealed the resider mattress with the factions of the section of	, 2010 through December 15, locumentation the physician's		the Social Services Director of Nursing or Survices Director	ctor, licensed mation identifying ing, Assistant	-
	alert, oriented, and of ease. Interview with the So 16, 2010, at 8:10 a.m office confirmed no kneed in regards to Hoterview with the Dir December 16, 2010.	carried on conversation with clai Worker on December n., in the Social Services crowledge of the physician's ct with the family had been OSPICE.' ector of Nursing on at 8:20 a.m., at the nurse's		Development Coordinate the physician progress not times four (4) weeks ther times two (2) months to any recommendations has addressed. Results will be at the Performance Improcommittee for further recommendations and/or	or will audit otes weekly in monthly ensure that ive been been overnent (PI)	
SS≃D	resident for HOSPICI addressed. 483.20(k)(3)(i) SERV PROFESSIONAL ST. The services provided	physician's plan to refer the E services had not been ICES PROVIDED MEET ANDARDS or arranged by the facility all standards of quality.	F 281	and follow up as needed. committee consists of Ad Director of Nursing Servi Assistant Director of Nur Services, Maintenance Di Medical Director, Busine Manager, Social Services Activities Director,	lministrator, ices, and sing irector, ss Office	
1	bv:	is not met as evidenced ord review, observation,		Admissions/Marketing Di Environmental Services D Staff Development, Nutri	Director,	

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DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICALD SERVICES
STATEMENT OF DEFICIENCIES
AND PLAN OF CORRECTION

(X1) PROVIDER/SUPPLIER/CLIA
IDENTIFICATION NUMBER:

& MEDICAID SERVICES

(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:

(X2) MULTIPLE CONSTRUCTION

A. BUILDING

B. WING

12/16/2010

· ** · * ** · ·		445319	B. Wif	1G_		12/16/2010	
	ROMDER OR SUPPLIER	CARE & REHABILITATION CENT	ER	33	EET ADDRESS, CITY, STATE, ZIP CODE 2 MEMORIAL DRIVE MNCHESTER, TN 37398		· · · · · · · · · · · · · · · · · · ·
(XA) ID PREFIX TAG	SUMMARY STA	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE	COMPLETION DATE
F 250	multifactorial. It is to chronic illness, chronic illness, chronutrition(gender) appropriate at this particular in the Social from September 22	from renal insufficiency, onic infection, and poor would be very HOSPICE point if the family agrees." Services documentation 12010 through December 15, incumentation the physician's	F	250	Services Director, Health Informanager, Therapy Program In Clinical Case Manager, and In Coordinator. All members at to attend monthly PI Commitmeetings. Compliance Date 1/10/11	Manager, MDS re invited	•
	revealed the resider mattress with the far sheet. Continued of the resident at this trainert, oriented, and ease. Interview with the State, 2010, at 8:10 a. office confirmed no	neember 14, 2010, at 5:10 p.m., at in bed, lying on an air ace partially covered with the bservation and interview with time revealed the resident was carried on conversation with colal Worker on December m., in the Social Services knowledge of the physician's act with the family had been HOSPICE.			F281 1. Resident #1 received her 4 of eye drops on 12/15/10. The physician was notified of the by the Director of Nursing on 12/15/10. Resident #1 did experience any complications these findings.	ie findings not	
F 281 SS=D	station confirmed the resident for HOSPIC addressed.	, at 8:20 a.m., at the nurse's e physician's plan to refer the CE services had not been	F 2	B1	2. The Director of Nursing at Development Coordinator con audits on 12/17/10 of resident physician orders and medicati availability and concerns were identified.	nducted 's on	
	must meet professio	ovided or arranged by the facility essional standards of quality. MENT is not met as evidenced			3. The Director of Nursing, S Development Coordinator and Assistant Director of Nursing	l	
	hv	cord review, observation,			provide re-education to licens nursing personnel regarding the	ed.	

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OMB NO. 0938-0391

12/16/2010

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

(X2) MULTIPLE CONSTRUCTION

(X3) DATE SURVEY

445319

A. BUILDING

B. WING_

COMPLETED

F 281 Continued From page 2 and interview, the facility failed to follow the physician's order for one (#21) of twenty-one residents reviewed. The findings included: Resident # 1 was admitted to the facility on November 17, 2009, with diagnoses including Congestive Heart Failure, Muscular Wasting and Disuse Alrophy, Atrial Fibriliation, and Psychosis. Medical record review of the Active Orders from 12/1/2010 to 12/31/2010 signed by the physician December 1, 2010, revealed "(brand name) Solution Opthalmic – TID (three times a day) 0800 (8:00 am) 1200 (12:00 pm) 1600 (4:00 pm) dry eyes" Observation during the B-Wing medication pass on December 15, 2010, at 7:40 a.m., revealed the Licensed Practical Nurse (LPN) did not have the ordered eye drops on the medication room, confirmed the eye drops were not available to administer to the resident as ordered by the physician. Interview with the B-Wing LPN in the physician. Interview with the B-Wing LPN in the physician orders by 1/7/10. 4. The Director of Nursing, Assistant Director of Nursing Assistant Director of Nursing Servician orders weekly times four (4) weeks then monthly times two (2) months. Results will be discussed at the Performance Improvement (PI) Committee for further recommendations and/or suggestions and follow up as needed. The PI committee consists of Administrator, Director of Nursing Services, Maintenance Director, Medical Director, Business Office Manager, Social Services Director, Admissions/Marketing Director, Environmental Services Director, Staff Development, Nutritional Services Director, Health Information	i		440010		, —		
SUMMARY STATEMENT OF DEFICIENCIES PREFIX TAG SUMMARY STATEMENT OF DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) PREFIX TAG			CARE & REHABILITATION CENT	rer .	33	2 MEMORIAL DRIVE	
and interview, the facility failed to follow the physician's order for one (#21) of twenty-one residents reviewed. The findings included: Resident # 1 was admitted to the facility on November 17, 2009, with diagnoses including Congestive Heart Failure, Muscular Wasting and Disuse Atrophy, Atrial Fibriliation, and Psychosis. Medical record review of the Active Orders from 12/1/2010 to 12/31/2010 signed by the physician December 1, 2010, revealed "(brand name) Solution Opthalmic - TID (three times a day) 0800 (8:00 am) 1200 (12:00 pm) 1800 (4:00 pm) dry eyes" Observation during the B-Wing medication pass on December 15, 2010, at 7:40 a.m., revealed the Licensed Practical Nurse (LPN) did not have the ordered eye drops on the medication room, confirmed the eye drops were not available to administer to the resident as ordered by the physician. Interview with the B-Wing LPN in the A-Wing hallway on December 15, 2010, at 2:12	(XA) ID PREFIX	SUMMARY STA	TEMENT OF DEFICIENCIES	ID PREF	t . tx	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE	(X5) COMPLETION DATE
8:00 a.m., and the 12:00 p.m., eye drops as ordered by the physician. F 283 SS=D RECAP STAY/FINAL STATUS When the facility anticipates discharge a resident must have a discharge summary that includes a Clinical Case Manager, and MDS Coordinator. All members are invited to attend monthly PI Committee meetings. Coordinator. All members are invited to attend monthly PI Committee meetings.	F 283 SS=D	Continued From parand interview, the faphysician's order for residents reviewed. The findings include Resident # 1 was at November 17, 2009 Congestive Heart Fabisuse Atrophy, Afril Medical record revising 12/1/2010 to 12/31/2000 am) 1200 (12: eyes" Observation during to on December 15, 200 Licensed Practical Nordered eye drops of administer. Interview on December 15, 200 Licensed Practical Nordered eye drops of administer to the resphysician. Interview A-Wing hallway on December 15, 200 a.m., and the 12 ordered by the physic 483.20(I)(1)&(2) ANT RECAP STAY/FINAL When the facility anti-	ge 2 collection failed to follow the rone (#21) of twenty-one ed: dmitted to the facility on with diagnoses including allure, Muscular Wasting and al Fibriliation, and Psychosis. We of the Active Orders from 2010 signed by the physician revealed "(brand name) TID (three times a day) 0800 on pm) 1600 (4:00 pm) dry the B-Wing medication pass 10, at 7:40 a.m., revealed the lurse (LPN) did not have the name the medication cart to our 15, 2010, at 7:45 a.m., in the medication room, ops were not available to ident as ordered by the with the B-Wing LPN in the recember 15, 2010, at 2:12 resident had not received the 2:00 p.m., eye drops as cian. ICIPATE DISCHARGE: STATUS	F2	281	to ensure medication availability and following physician orders by 1/7/10. 4. The Director of Nursing, Assistant Director of Nursing or Staff Development Coordinator will complete an audit of medication availability and following physician orders weekly times four (4) weeks then monthly times two (2) months. Results will be discussed at the Performance Improvement (PI) Committee for further recommendations and/or suggestions and follow up as needed. The PI committee consists of Administrator, Director of Nursing Services, and Assistant Director of Nursing Services, Maintenance Director, Medical Director, Business Office Manager, Social Services Director, Activities Director, Activities Director, Staff Development, Nutritional Services Director, Health Information Manager, Therapy Program Manager, Clinical Case Manager, and MDS Coordinator. All members are invited to attend monthly PI Committee meetings.	
recapitulation of the resident's stay; and a final	į,	recapitulation of the r	esident's stay; and a final		1		

12/30/2010 16:40 19319624224 WILLOWS PRINTED: 12/20/2010 FORM APPROVED DEPARTMENT OF HEALTH AND HUMAN SERVICES OMB NO. 0<u>938-0391</u> CENTERS FOR MEDICARE & MEDICAID SERVICES (X3) DATE SURVEY (X2) MULTIPLE CONSTRUCTION (X1) PROVIDER/SUPPLIER/CLIA COMPLETED STATEMENT OF DEFICIENCIES IDENTIFICATION NUMBER: AND PLAN OF CORRECTION A. BUILDING B, WING_ 12/16/2010 445319 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 32 MEMORIAL DRIVE WILLOWS AT WINCHESTER CARE & REHABILITATION CENTER WINCHESTER, TN 37398 PROVIDER'S PLAN OF CORRECTION (X5) COMPLETION SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) ID (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE PREFIX PRÉFIX TAG DEFICIENCY) TAG F 283 Continued From page 3 F283 F 283 summary of the resident's status to include items in paragraph (b)(2) of this section, at the time of 1. Resident # 14 was discharged from the discharge that is available for release to the facility on June 14, 2010. authorized persons and agencies, with the Resident #15 was discharge from the consent of the resident or legal representative. facility on June 5, 2010. Resident #17 was discharged from the This REQUIREMENT is not met as evidenced

Based on medical record review and interview, the facility failed to ensure discharge summaries were complete to reflect a summary of the resident's stay, for three (#14, #15, #17) of twenty-one residents reviewed.

The findings included:

Medical record review revealed resident #14 was admitted to the facility on May 7, 2010, with diagnoses including Hypertension, Osteoporosis, Depression, Asthma, and MRSA (Methicillin Resistant Staphylococcus Aureus) in right hip wound. Continued medical record review revealed the resident was discharged on June 14, 2010, to an acute care hospital for wound care. Further review of the medical record and the discharge summary revealed the sections on Final Diagnosis, Brief History, Pertinent Physician and Laboratory Findings, and Condition on Discharge were not completed.

Medical record review revealed resident #15 was admitted to the facility on March 8, 2008, with diagnoses including Closed Head Injury, Hepatitis C, Herniplegia, Hypertension, and Seizures. Continued medical record review revealed the resident was discharged on June 5, 2010, to a facility with a Behavioral Unit. Further review of the medical record and discharge summary

- facility on November 11, 2010.
- 2. The Director of Nursing, Assistant Director of Nursing and Staff Development Coordinator will review the last 5 discharges from the facility by 12/31/10 and ensure the Recapitulation of Stay is complete.
- 3. The Director of Nursing will reeducate the Interdisciplinary Team on completion of the Recapitulation of Stay form for discharged residents by 1/7/10.
- 4. The Director of Nursing, Assistant Director of Nursing, Staff Development Coordinator or Health Information Manager will audit the Recapitulation of Stay form for completion weekly times four (4) weeks then monthly times two (2)

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DEPARTMENT OF HEALTH	AND HUMAN SERVICES	
DEPARTMENT OF THE PARTY	A LUEDICAID SERVICES	
CENTERS FOR MEDICARE	& MEDICAID SERVICES	
CALLALET CO. C.		MULTIPLE CONS

OMB NO. 0938-0

		(X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CONSTRUCTION	(X3) DATE SU COMPLE	JRVEY TED
STATEMENT AND PLAN O	OF DEFICIENCIES F CORRECTION	IDENTIFICATION NUMBER:		LDING		
		445319	B, WIN			6/2010
NAME OF P	ROVIDER OR SUPPLIER	CARE & REHABILITATION CENT	ER	STREET ADDRESS, CITY, STAT 22 MEMORIAL DRIVE WINCHESTER, TN 3739	38	
(X4) ID PREFIX TAG	SUMMARY STA	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	X (EACH CORRECTIVI CROSS-REFERENCED DEFIC	N OF CORRECTION E ACTION SHOULD BE O TO THE APPROPRIATE CIENCY)	(X5) COMPLETION DATE
F 323 SS=D	revealed the section History, Pertinent F Findings, and Concompleted. Medical record reviadmitted to the facidiagnoses including Pulmonary Disease Arthritis, and Degel Continued medical resident was dischate an acute care he medical record and the sections on Finder Pertinent Physical a Condition on Dischall Interview with the Linguist on Conditio	rs on Final Diagnosis, Brief Physical and Laboratory dition on Discharge were not ew revealed resident #17 was dity on October 25, 2010, with g Chronic Obstructive g, Hypertension, Rheumatoid herative Joint Disease. record review revealed the arged on November 11, 2010, spital. Further review of the discharge summary revealed al Diagnosis, Brief History, and Laboratory Findings, and arge were not completed. icensed Practical Nurse on December 15, 2010, at 3:40 station, confirmed the es were not complete for the	F 3	the Performance In Committee for fur recommendations and follow up as no committee consist Director of Nursin Assistant Director Services, Mainten Medical Director, Manager, Social Stativities Director, Admissions/Marke Environmental Services Director, Manager, Therapy Clinical Case Man Coordinator. All no attend monthly meetings. Compliance Date	ther and/or suggestions needed. The PI is of Administrator, ng Services, and of Nursing ance Director, Business Office fervices Director, rvices Director, it, Nutritional Health Information of Program Manager, nager, and MDS members are invited PI Committee	
-	by: Based on medical re	T is not met as evidenced ecord review, observation, cility failed to ensure a safety		of Nursing replace	e Assistant Director d the pressure pad or resident #4. The of Nursing secured	

DEPART	MENT OF HEALTH	AND HUMAN SERVICES			•	FORM. OMB NO.	0938-039
CENTER	RS FOR MEDICARE	& MEDICAID SERVICES	CC2) MI	IJLTI	PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
TATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA (DENTIFICATION NUMBER:	A. BUII			COMPLE	ובט
		44531 9	8. WIN	IG		12/1	6/2010
WARE OF B	ROVIDER OR SUPPLIER			STF	REET ADDRESS, CITY, STATE, ZIP CODE		
		DADE & DEMARK ITATION CENT	ER		2 MEMORIAL DRIVE		•
MILLOW	S AT WINCHESTER	CARE & REHABILITATION CENT		ν	VINCHESTER, TN 37398 PROVIDER'S PLAN OF CORRECT	TON	(XD)
(X4) ID PREFIX TAG		ITEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFL TAG		(EACH CORRECTIVE ACTION SHOL CROSS-REFERENCED TO THE APPR DEFICIENCY)	NTD RE	(X5) COMPLETION DATE
		E	F 3	123	the oxygen tank in room 109	on	
F 323	Continued From pa	ge 5	, ,		12/14/10. The Maintenance	Director	
	residente roviouxod	for one (#4) of twenty-one failed to ensure an oxygen			locked the laundry access do	or on	
	tank was secured. 8	and failed to ensure doors war I			12/14/10.		
	lead to hazardous a	ireas were locked.			A G 40/44/0040 It To		
	The findings include	ed:			2. On 12/14/2010 the Direct		
		;			Nursing, Assistant Director of	y musing	l
	Resident #4 was at	Imitted to the facility on June			and the Staff Development Coordinator audited residents	n with an	
	4, 2008, with diagno	oses including Dementia,			order for pressure sensitive a		
	Hypertension, Osteoporosis, and Abnormality of Gait. Continued record review revealed the				ensure the devices were in pl		
	resident had a histo	ry of falls. Review of the			oxygen tanks were secured.		
	Minimum Data Set	dated September 14, 2010,			that require to be locked were		
ł	revealed the resider	nt had short/long term gnit/ve impairment, and			by the Maintenance Director		
	required extensive	assist with transfers.			12/14/10.	VA.	
	Review of the physi-	cian's recapitulation orders					
	dated December 1	2010 to December 31, 2010. I			3. The Director of Nursing, A		į
	revealed, an order f	or "Pressure sensitive ded			Director of Nursing and Staff		
i	alarm nurse to chec	K C (every) sime			Development Coordinator wi	ii provide	i
	Observation and into	erview with the Licensed			re-education to staff on reside		
ļ	Practical Nurse for /	4-Wing on December 14,		- [environment remaining free o		1
i	2010, at 7:30 p.m., i	in the resident's room,			accident hazards, supervision		;
	confirmed the reside pressure pad alarm	ent was in bed, and the			assistance devices to prevent:	accidents	:
	•				by 1/7/10.		
	Observation during t	the initial tour in Room 109 on			4. The Director of Nursing, A	ecietant	i
}	December 14, 2010	, at 5:25 p.m., revealed an		ĺ	Director of Nursing or Staff	morani	•
	unsecured oxygen to	ank laying in the geri-chair in Continued observation of the		Į	Development Coordinator wil	1	: •
Į.	A-Wing at this time t	revealed an unlocked door			complete audits to ensure pres		
	across the hall from	resident Room 107.			alarm devices are in place and		
1	Observation reveale	d the door opened into the			tanks are secured. The Mainte		
1	back of large equipm	nent and electrical			Director will complete audits		
İ	connections.				doors that need to be locked for		
	interview with the Ma	aintenance Supervisor on			are locked. The audits will be		ĺ
1	Charterna dermi min itte			- 1	THE REALITY WILL BE	<u> </u>	

DEPAS	TMENT OF HEALTH	AND HUMAN SERVICES				FORM OMB NO.	0938-0391
CENTE	RS FOR MEDICARE	& MEDICAID SERVICES	Cotes to		IPLE CONSTRUCTION	(X3) DATE SE	JRVEY
STATEMEN	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BU			COMPLE	TEÒ (SET)
		44531 9	B. WIN	/G _		12/1	6/2010
	PROVIDER OR SUPPLIER	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,		ST	REET ADDRESS, CITY, STATE, ZIP CODE		
		SART & REMARK STATION CENT	ER		22 MEMORIAL DRIVE		
WILLOV	VS AT WINCHESTER I	CARE & REHABILITATION CENT		\	MINCHESTER, TN 37398	EION .	/X5)
(X4) ID PREFIX TAG	「 ・・・・・・・・・・・・・・・・・・・・・・・・・・・・・・・・・・・・	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC (DENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE	(XS) COMPLETION DATE
			F :	323	completed weekly times four	(4)	
F 323	Continued From pa	ge to	, ,	JE U	weeks then monthly times (2)		
	December 14, 2010), at 5:25 p.m., confirmed the tree secured properly.			Results will be discussed at the		
	I Continued inferview	, revealed the unidentified, 🔠			Performance Improvement (F	PT)	
	unlocked door oper	ned into the laundry room, and			Committee for further	•	
	should have been to	ocked to prevent unauthorized interview confirmed the rear			recommendations and/or sugg	gestions	
	door to the laundry	was used for accessing the			and follow up as needed. The	e PI	
	back of the dryers for	for cleaning and maintenance			committee consists of Admin	, ,	
	ригрозе\$ оліу.		E 9	371	Director of Nursing Services,		
F 371	1:	SERVE - SANITARY	ΓĢ	,,,	Assistant Director of Nursing		
SS=E	1 2 LOVELLUELVINE	OEI(VE C) III I V	-		Services, Maintenance Direct	•	
	The facility must -				Medical Director, Business O		
	(1) Procure food fro	m sources approved or			Manager, Social Services Dire	ector,	i
	considered satisfact authorities; and	ory by Federal, State or local			Activities Director,		
	(2) Store, prepare, 0	listribute and serve food		ļ	Admissions/Marketing Direct Environmental Services Direc		
	under sanitary cond	itions		ı	Staff Development, Nutritiona	- 1	
				}	Services Director, Health Info		
		İ			Manager, Therapy Program M		
					Clinical Case Manager, and M		
		T is not met as evidenced			Coordinator. All members are		
	This REQUIREMEN	I is not mer as chidenced			to attend monthly PI Committee		
	Based on observation	n during the Initial tour of the		ì	meetings.		
	facility, the facility fai	led to ensure food for the				İ	
	residents was stored	in a sale manner.			Compliance Date 1/10/11		· ·
	The findings included	d:				ĺ	1
	Observation during t	he initial tour on December		į	·		1
}	14, 2010, at 5:30 p.m	n., of the refrigerator in the			F371		
	ice Room on C-wing,	revealed two plastic food labeled with the name				:]
ĺ	of a resident on the C	C-wing, and there was no			1. The Nutritional Services Dir	ector]
i	date on the container	s to indicate when they were			and Registered Dietician remov		1
J	placed in the refrigera	ator,			pureed food, cheese slices, Mou		1
]	Dew and sandwich that were no	<u>t </u>	

DEPARTMENT OF HEALTH AND HUMAN SERVICES

PRINTED: 12/20/2010 FORM APPROVED CENTERS FOR MEDICARE & MEDICAID SERVICES <u>OMB NO. 0938-0391</u> STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY COMPLETED AND PLAN OF CORRECTION A. BUILDING B. WING 445319 12/16/2010 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 32 MEMORIAL DRIVE WILLOWS AT WINCHESTER CARE & REHABILITATION CENTER WINCHESTER, TN 37398 (X4) ID PREFIX SUMMARY STATEMENT OF DEFICIENCIES ID PREFIX PROVIDER'S PLAN OF CORRECTION (X5) COMPLETION (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) (EACH CORRECTIVE ACTION SHOULD BE TAG CROSS-REFERENCED TO THE APPROPRIATE TAG DATE DEFICIENCY F 371 Continued From page 7 labeled and dated from the refrigerator F 371 Continued observation of the Ice Room in the C-wing ice room on 12/14/10. refrigerator revealed several slices of cheese in a plastic bag, labeled with the name of a resident 2. The Nutritional Services Director who had been discharged, but no date on the bag conducted a review of the refrigerators to indicate when it was placed in the refrigerator. to identify any other items that were Further observation of the Ice Room refrigerator undated and removed them on revealed a bottle of Diet Mountain Dew, partly 12/14/10. consumed, with no label or date to indicate when it was placed in the refrigerator. 3. The Staff Development Continued observation of the ice Room revealed Coordinator or Nutritional Services a sandwich in a pharmacy bag labeled with the Director will re-educate staff on name of a resident on the A-wing, but no date on labeling and dating food and liquids the bag to indicate when it was placed in the placed in refrigerators by 1/7/11. refrigerator. Interview with the Licensed Practical Nurse 4. The Housekeeping Supervisor or responsible for C-wing on December 14, 2010, at housekeeping staff will audit the 5:45 p.m., in the Ice Room, confirmed the refrigerators daily to ensure that food containers of pureed food, silces of cheese, items are labeled and dated. The daily sandwich, and Mountain Dew were not dated to audit sheets will be provided to the PI indicate when they were placed in the refrigerator. 483.65 INFECTION CONTROL, PREVENT committee every month times three (3) F 441 SS=E | SPREAD, LINENS months. Results will be discussed at the Performance Improvement (PI) The facility must establish and maintain an Committee for further Infection Control Program designed to provide a recommendations and/or suggestions safe, sanitary and comfortable environment and and follow up as needed. The PI to help prevent the development and transmission of disease and infection. committee consists of Administrator, Director of Nursing Services, and (a) Infection Control Program Assistant Director of Nursing The facility must establish an Infection Control Services, Maintenance Director. Program under which it -(1) Investigates, controls, and prevents infections Medical Director, Business Office in the facility:

(2) Decides what procedures, such as isolation,

should be applied to an Individual resident; and

Manager, Social Services Director,

Admissions/Marketing Director,

Activities Director,

DEPARTMENT OF HEALTH AND HUMAN SERVICES PRINTED: 12/20/2010 CENTERS FOR MEDICARE & MEDICAID SERVICES FORM APPROVED STATEMENT OF DEFICIENCIES OMB NO. 0938-0391 (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION IDENTIFICATION NUMBER: (X3) DATE SURVEY COMPLETED A, BUILDING B. WING 445319 NAME OF PROVIDER OR SUPPLIER 12/16/2010 STREET ADDRESS, CITY, STATE, ZIP CODE WILLOWS AT WINCHESTER CARE & REHABILITATION CENTER 32 MEMORIAL DRIVE WINCHESTER, TN 37398 SUMMARY STATEMENT OF DEFICIENCIES (X4) ID PROVIDER'S PLAN OF CORRECTION
(EACH CORRECTIVE ACTION SHOULD BE
CROSS-REFERENCED TO THE APPROPRIATE PREFIX ID. (EACH DEFICIENCY MUST BE PRECEDED BY FULL (X5) COMPLETION PREFIX TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG DATE DEFICIENCY F 441 Continued From page 8 F 441 Environmental Services Director, (3) Maintains a record of incidents and corrective Staff Development, Nutritional actions related to infections. Services Director, Health Information (b) Preventing Spread of Infection Manager, Therapy Program Manager, (1) When the Infection Control Program Clinical Case Manager, and MDS determines that a resident needs isolation to Coordinator. All members are invited prevent the spread of infection, the facility must to attend monthly PI Committee isolate the resident. meetings. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if Compliance Date 1/10/11 direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice. F441 (c) Linens 1. Resident #10's oxygen tubing was Personnel must handle, store, process and replaced and put in a bag on 12/14/10 transport linens so as to prevent the spread of by the Director of Nursing. On infection. 12/14/10 the Director of Nursing, Assistant Director of Nursing and Staff Development Coordinator This REQUIREMENT is not met as evidenced changed the nebulizer, mask and mouth piece for identified residents on Based on observation and interview, the facility failed to ensure a sanitary environment to B and C wing. The Director of prevent the development and transmission of Nursing replaced the blood pressure disease for one (#10) using oxygen and two cuffs and stethoscopes found lying random residents with nebulizers of twenty-one across the biohazard sharps container residents reviewed and for three of three before 1/7/10. medication carts. The findings included: 2. The Director of Nursing, Assistant

Observation on December 14, 2010 at 5:23 p.m.,

revealed resident #10 not in the room and the

oxygen concentrator was working. Further

Director of Nursing and Staff

Development Coordinator completed a

review of residents with oxygen and

nebulizers to ensure they were in bag

DEPARTMENT OF HEALTH AND homan SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEME	NT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	- John III	1)	OMB N	O. 0938-0
AIVO PLAN	OF CORRECTION	IDENTIFICATION NUMBER:		JLTIPLE CONSTRUCTION	(X3) DATE	SURVEY
			A. BUIL	·	COMP	LETED
NAME OF	Direct control of the	445319	B. WING	S	1	
	PROVIDER OR SUPPLIER		<u> </u>	TREET ADDRESS COM ATTAC	12/	16/2010
MILLON	NS AT WINCHESTER (ARE & REHABILITATION CE	ENTED (STREET ADDRESS, CITY, STATE, ZIP COO 32 MEMORIAL DRIVE	E	
		<u> </u>	MICK	WINCHESTER, TN 37398		
(X4) ID PREFIX	I GOVERNICY	EMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL	ID	PROVIDER'S PLAN OF CORR	ECTION	
F 441	THEODENION OR ES	C (DENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AF DEFICIENCY)	はつけ ちゃゃ	COMPLETION DATE
F 441	i a arrestada e tabiti bag	e 9	F 44	when not in use on 12/17/1	0 This	
	observation revealed	the oxygen tubing lying		review also included blood	Drecembe O' 1102	
- 1	i acioss his Midfil OLfi	le bed with the nagal canoni	la	cuffs and stethoscopes to er	hrespire	
j	floor.	of the bed just above the		were not on top of the bioha	nanty meric titel	4
1				sharps containers.	-341 (I	
	Interview with the BV	/ing Licensed Practical				
-	Nurse, responsible for	the care of the resident, or	1	3. The Director of Nursing.	Assistant	
{;	December 14, 2010 a	t 5:24 p.m., in the resident's ibing and nasal cannula	i	Director of Nursing or Staff		
- 1	were to be stored in a	Sealable bao when not in		Development Coordinator w	ill re-	
	use in order to preven	infection.		educate staff on the storing of	foxvoen	
		•	1 1	rubing, nebulizer mask and n	nouth	
ار	Theervation on Docem	nber 14, 2010 at 5:45 p.m.,	1	piece in bag when not in use	and not	
ir	n a random residents	room on B Wing, revealed]	placing blood pressure cuffs :	and	
¦ a	n uncovered nebulize	r machine on the bedside	}	stethoscopes on biohazard sha	arps	
j t≊	able. Further observat	ion revealed the nebulizer i		containers by 1/7/11.		- 1
l m	ompartment lid propper pask stored in the com	ed open by the tubing and		A THE BY A SE		
of	bservation revealed th	Pariment, Furmer 9 Mask and nebulizer		4. The Director of Nursing, A	ssistant	- 1
We	ere not covered.	- THE TODOLLE] ,	Director of Nursing or Staff	. ;	- 1
1	kå den en bestaar		} ;	Development Coordinator wil	l)	ĺ
No	terview with the B Win	g Licensed Practical ne care of the resident, on		complete infection control and	lits to	1
De	cember 14, 2010 at 5	:52 p.m., confirmed the	1 2	nclude oxygen tubing, nebuliz	zer mask	[
ne	bulizer and the mask	were to be stored in a		and mouth piece in a bag wher use and medication carts to ens	not m	
sea	alable bag when not in	use in order to prevent	1	lood pressure cuffs and stetho	sure	1
	ection.	nitial tour on December	la	re not placed on top of biohaz	scopes	- 1
14.	, 2010, at 4:55 p.m., In	a random residente	s s	harps containers. The audits v	ard	- 1
, roo	m on C-wing, reveale	d a nebulizer with mouth	l o	ompleted weekly times four (4	AITI DE .	- 1
pie	ce lying uncovered on	the compartment.	W	reeks then monthly times two	(2)	1
Into	orview with the License	nd Bracklant Muses	m	onths. Results will be discussed	ed of	[
resi	ponsible for C-wing, c	onfirmed the nebulizer	th	e Performance Improvement (אַ אַנּ]
(was	s uncovered and was t	o be contained in a	C	ommittee for further	^*/	- 1
plas	stic bag with drawstring	when not in use.		commendations and/or sugges	tions	ľ
05-	onestine duvine the —		an	d follow up as needed. The PI	WO113	- 1
Uus	servation during the ma	culcation pass on	co	mmittee consists of Administr	ator,	- 1

12/30/2010 16:40 19319624224 WILLOWS DEPARTMENT OF HEALTH AND I. AN SERVICES PRINTED: 12/20/2010 CENTERS FOR MEDICARE & MEDICAID SERVICES FORM APPROVED STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: OMB NO. 0938-0391 AND PLAN OF CORRECTION (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY A BUILDING COMPLETED 445319 B. WING NAME OF PROVIDER OR SUPPLIER 12/16/2010 STREET ADDRESS, CITY, STATE, ZIP CODE WILLOWS AT WINCHESTER CARE & REHABILITATION CENTER 32 MEMORIAL DRIVE WINCHESTER, TN 37398 SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL (X4) ID PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE PREFIX ID REGULATORY OR LSC IDENTIFYING INFORMATION) TAG PREFIX COMPLETION DATE TAG DEFICIENCY) F 441 Continued From page 10 Director of Nursing Services, and F 441 December 15, 2010, at 7:40 a.m., revealed two Assistant Director of Nursing stethoscopes and two blood pressure cuffs laying Services, Maintenance Director, across the top of the biohazard sharps container Medical Director, Business Office on the side to the B-Wing medication cart. Manager, Social Services Director, Observation of the A-Wing medication cart on Activities Director, December 15, 2010, at 8:15 a.m., revealed a Admissions/Marketing Director, blood pressure cuff laying across the top of the Environmental Services Director, biohazard sharps container on the side of the Staff Development, Nutritional medication cart. Services Director, Health Information Observation of the C-Wing medication cart on Manager, Therapy Program Manager, December 16, 2010, at 9:00 a.m., revealed a Clinical Case Manager, and MDS blood pressure cuff laying across the top of the Coordinator. All members are invited biohazard sharps container on the side of the to attend monthly PI Committee medication cart. meetings. Interview with the Director of Nursing on December 16, 2010, at 11:30 a.m., at the nurse's Compliance Date 1/10/11 station confirmed stathoscopes and blood pressure cuffs (clean items) should not be placed on the blohazard sharps container (dirty area.) F 514 483.75(I)(1) RES F:514 SS=E | RECORDS-COMPLETE/ACCURATE/ACCESSIB F514 1. Resident's # 2, # 5, # 7, and #12 The facility must maintain clinical records on each will be re-assessed for pain and resident in accordance with accepted professional standards and practices that are complete:

accurately documented; readily accessible; and systematically organized.

The clinical record must contain sufficient information to identify the resident; a record of the resident's assessments; the plan of care and services provided; the results of any preadmission screening conducted by the State: and progress notes.

- medical record updated to reflect current status by the Director of Nursing or Assistant Director of Nursing before 12/31/10.
- 2. The Director of Nursing, Assistant Director of Nursing and Staff Development Coordinator conducted a review of residents to ensure that pain has been re-assessed and that the

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMEN	NT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	1001.201	t trulai — — —	OMB NO	D. 0938-03
I AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILE	LTIPLE CONSTRUCTION DING	(X3) DATE : COMPL	SURVEY ETED
		445319	B. WING		1	
NAME OF	PROVIDER OR SUPPLIER		—! <u> </u>		12/1	16/2010
WILLOW		ARE & REHABILITATION CEN	TER !	TREET ADDRESS, CITY, STATE, ZIP CODE 32 MEMORIAL DRIVE WINCHESTER, TN 37398		
(X4) ID PŘÉFIX	SUMMARY STAT	EMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRE	CTION	
TAG	REGULATORY OR LS	MUST BE PRECEDED BY FULL C IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHI CROSS-REFERENCED TO THE APP DEFICIENCY)	niii n ee	COMPLETION DATE
F 514	Continued From pag	e 11	F 514	Medication Administration R	lecord,	
	This REQUIREMENT	is not met as evidenced		Pain Management flow sheet	and	
1	by:			Controlled drug record reflec	ts	
}	review, Consultant Pf	cord review, facility policy parmacy Report review, and	i	residents current status before	: 1/7/11.	
1	interview, the facility f	ailed to maintain complete		3. The licensed nurses will be	2 TA_	
	and accurate medical	records for four (#2, #5, #7)		educated on completing Medi	ration	
ļ;	#12) of twenty-one res	sidents reviewed.		Administration Records, Pain	овцод	
-	The findings included:		j	Management flow sheets and		
	· · · · · · · · · · · · · · · · · · ·	<u> </u>		Controlled Drug records by th	.	
F	Resident #2 was admi	tted to the facility on June	.]	Director or Nursing or Staff	·	
\ \{\s\ \\ \\ \\ \\ \\ \\ \\ \\ \\ \\ \\ \\	3, 2010, with diagnose Spinal Cord Injury, and	s including Chronic Pain, Multiple Pressure Lilcers		Development Coordinator by	1/7/10.	
"	Lower Back, Knee, A	Ankle and Hip.		4. The Director of Nursing, As	saiotont	ĺ
l N	ledical record review i	of the Minimum Data Set	1	Director of Nursing or Staff	SISTAUL	1
di	ated September 6, 20	10 revealed the resident		Development Coordinator will	andie !	- 1
ha	ad no memory or cogi	nitive deficit and had	l i	the Medication Administration	audit	1
m	oderate pain.	1		Records, Pain Management flo		1
No.	edical record review o	file shusini	- 5	sheets and Controlled Drug Rec	ward to	- 1
Re	ecapitulation orders fo	r December 2010	l e	msure they match weekly times	A farm	
re	vealed "Hydrocodon	e-Acetaminophen 5-325	10	4) weeks then monthly times to	(2)	i
mi	iligrams 1 tablet by m	outh every 4 hours as	Ì	Results will be discussed at the	νο (<i>2)</i> .	- 1
ле	eded (PRN) for páin	."		erformance Improvement (PI)	1	- 1
840	المرادية المحمود المراد	tales against the	10	Committee for further	1	
	dical record review of	MAR) for December 2010			41	ĺ
rev	realed a total of seven	administrations of the	21	ecommendations and/or sugges nd follow up as needed. The P	dons	- 1
	N Hydrocodone-Aceta		\ \frac{\alpha}{\cdot \cdot \c	ommittee consists of Administr		
1		1	η	irector of Nursing Services, and	ator,	
Me	dical record review of	the Controlled Drug		ssistant Director of Nursing	-	- 1
Hum	ord dated December frocodone-Acetamino	20 (U IDI (NE PRN	S ₂	ervices, Maintenance Director,		-
twe	nty-nine administration	rien, levealeu is.	M	edical Director, Business Offic	_	1
		}	7.V	anger Social Series D'	e	j
Med	lical record review of (he Pain Management	A.	anager, Social Services Directo	T ,	
Flov	v Sheet for December	2010 revealed a total of			:	1
			AC	lmissions/Marketing Director,	Н	1

DEPARTMENT OF HEALTH AND HOMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

	STATEME	NT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	21241			OMB N	O. 0938-039
	ANU PLAN	OF CORRECTION	IDENTIFICATION NUMBER:		MULTI MULTI	PLE CONSTRUCTION G	(X3) DATE SURVEY COMPLETED	
ŀ	VALUE OF		445319	B. Wil	NG		1	
l	NAME OF	PROVIDER OR SUPPLIER		i	STPI	CET ADDRESS AITH	12/	16/2010
L	WILLOW	VS AT WINCHESTER C	ARE & REHABILITATION CEN	VITER	32	RET ADDRESS, CITY, STATE, ZIP CODE MEMORIAL DRIVE INCHESTER, TN 37398		
	(X4) (D PREFIX	SUMMARY STAT	EMENT OF DEFICIENCIES	10	 -		 -	
_	TAG	REGULATORY OR LS	MUST BE PRECEDED BY FULL C (DENTIFYING INFORMATION)	PREFO TAG	x	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	litin pe	(X5) COMPLETION DATE
	F 514	Continued From pag	e 12	FS	14	Environmental C	······································	 -
	j	two pain evaluations	with the PRN	1	'-'	Environmental Services Dire	ctor,	
		Hydrocodone-Acetan	ninophen as an intervention.			Staff Development, Nutrition	al	
		Review of the facility	policy entitled "6.0 General	1		Services Director, Health Info Manager, Therapy Program N	rmation	
		Dose Preparation and	Medication Administration			Clinical Case Manager, and M	ianager,	
		enecove 12/01/07. fet	/ised_5/01/10" rouppled		C	-cordinator. All members are	hadirai e	- 1
	J,	"Procedure:5. Du administration, Facility	nng medication (staff should toke all]	to	attend monthly PI Committ	ec v minited	- 1
	1.0	measures required by	Facility policy and		n	neetings.		}
	/	Applicable Law, Includ	ing, but not limited to the			•		- 1
	following:5.5. Document the administration of controlled substances in accordance with					ompliance Date 1/10/11		1
	Ι.Α.	\pplicable Law;6, At	fter medication				1	- 1
	∣ a	oministration, Facility	staff should take all					
	II	neasures required by I	Facility policy and ng, but not limited to the				1	- 1
	fo	blowing:6.1 Docume	ent necessary medication			•		1
	į ac	oministration/treatmen	it information (e.g., when		1			
	Į m	edications are given, opropriate forms;,"	PRN medications,) on			•		- 1
		propriate fortis,		·				- 1
	Re	eview of the facility Pa	in Management Program	1		•		1
	re _'	vealed "PRN Pain M	ledication When	1			1	- 1
	ep	algesics are administr Isode of pain, licensed	ered in response to an if nurses must document	1				
	(the	ar evaluation, treatme	nt and effectiveness of			•	j	1
	the	treatment on the PRI	N Pain Management Flow	1				- 1
	ອັກເ the	eet I ne flow sheet re I following information:	equires documentation of 1. Pain evaluation and					
	trea	atment Date and time	i. Pain evaluation and [- 1
	l Noi	n-pharmacological trea	atment provided.			•	i	ł
	Loc	ation of pain, Medicat	ion dose"	1				
	Inte	rview, with the Staff C	oordinator on December				1	
	16,	2010 at 11:12 a.m., in	the nursing station.			•		- 1
	cont	firmed the December :	2010 MAR, Controlled	1				1
	Drug	g Record and Pain Ma not match and the med	nagement Flow Sheet	}				J
	com	plete or accurate.	alcai (ecord was not					- 1
			j				1	ł

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DEPARTMENT OF HEALTH AND HUMAN SERVICES PRINTED: 12/20/2010 CENTERS FOR MEDICARE & MEDICAID SERVICES FORM APPROVED STATEMENT OF DEFICIENCIES OMB NO. 0938-0391 (X1) PROVIDER/SUPPLIER/CLIA (XZ) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION (X3) DATE SURVEY COMPLETED IDENTIFICATION NUMBER: A. BUILDING B. WING 445319 NAME OF PROVIDER OR SUPPLIER 12/16/2010 STREET ADDRESS, CITY, STATE, ZIP CODE WILLOWS AT WINCHESTER CARE & REHABILITATION CENTER 32 MEMORIAL DRIVE WINCHESTER, TN 37398 SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) (X4) ID PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE ΙĐ PRÉFIX (XS) COMPLETION PREFIX TAG TAG DEFICIENCY) F 514 Continued From page 13 F 514 Resident #5 was admitted to the facility on September 11, 2010, and readmitted on December 10, 2010, with diagnoses including Stage IV Chronic Kidney Disease, Chronic Ischemic Heart Disease, Congestive Heart Failure, Peripheral Vascular Disease, Varicose Veins Lower Extremities with Ulceration and Inflammation, and Diabetes Mellitus. Medical record review of the Minimum Data Set dated September 21, 2010 revealed the resident had no cognitive or memory deficit and mild pain. Medical record review of the physician Recapitulation orders for November and December 2010 revealed "...Hydrocodone-Acetaminophen 5-325 milligram Tablet by mouth as needed (PRN): may have 2 tablets every (q) 6 hours PAIN..." Medical record review of the Medication Administration Record (MAR) for November 2010 revealed a total of twenty-two administrations of the PRN Hydrocodone-Acetaminophen. Review of the December 2010 MAR revealed a total of nine administrations of the PRN Hydrocodone-Acetaminophen. Medical record review of the Controlled Drug Record for November 2010 of the PRN Hydrocodone-Acetaminophen revealed a total of thirty administrations. Review of the December 2010 Controlled Drug Record revealed a total of fifteen administrations of the PRN Hydrocodone-Acetaminophen. Medical record review of the Pain Management

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CENT	DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES					FOR	D: 12/20/2010 M APPROVED	
ISTATEME	NT DE DEFICIENCICO	(X1) PROVIDER/SUPPLIER/CLIA	·····			OMB NO. 0938-039		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	(xs)	(XR) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE		
ł		1	A, B			COMP	LETED	
L.		445319	B. W	ING				
NAME OF	PROVIDER OR SUPPLIER		L	"		12/	16/2010	
	•			STRE	ET ADDRESS, CITY, STATE, ZIP CODE			
AAITTO	WO AT WINCHESTER (CARE & REHABILITATION CENT	ER		MEMORIAL DRIVE			
(X4) iD	SUMMARY STA	TEMENT OF DEFICIENCIES			NCHESTER, TN 37398		·	
PREFIX TAG	I CEACH DEFICIENCY	MUST RE PRECEDEN DV EUL	' ID PREF	IX	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU	TON ILD DE	(X5) COMPLETION	
170	WESOEVIORS OF ES	C IDENTIFYING INFORMATION)	TAG	i	CROSS-REFERENCED TO THE APPR	OPRIATE	DATE	
F 514	C				DEFICIENCY)		<u>l</u> 1	
17 014	1 and the part has		F 8	14	•			
	FIOW Sheet for Nove	mber 2010 revealed a total of						
	Six pain evaluations	wan the PKN		-				
	1 . Aniacogolia-Vocisi	ninophen as the intervention.			-		- 1	
	Interview, with the Ad	fministrator and Director of					1	
	Nursing on Decembe	of 15, 2010 at 4:35 nm at					1	
- 1	the nursing station, or	Onfirmed the PRN						
	medication document	tion on the MAR, Controlled		-			j	
ſ	did not match on that	n Management Flow Sheet			•	1	J	
	accurate or complete.	the medical record was not				- 1	- 1	
-							İ	
ļ						1	- 1	
jį	Resident #7 was admi	Itted to the facility on		}			ŀ	
} (December 18, 2008, v	vith diagnoses including					- 1	
1 1	ramological Fracture	of Humerus, Disorder of				1	1	
	Disease, Chronic Ische	te Effect Cerebrovascular		1			ĺ	
] [Diabetes Mellitus, Mali	gnant Neoplasm of Breast,					- 1	
a	ind Osteoporosis.	griding recopidatify of Breast,					1	
	•	1		1			J	
∫ M	fedical record review of	of the Minimum Data Set		1			.]	
Q	ated October 21, 2010	revealed the resident had			•	- 1	- 1	
100	ognitive and memory (deficit and moderate pain.					1	
м	edical record review o	if the physician	1				- 1	
R	ecapitulation orders fo	r November and	l		<u>.</u>	- 1	- 1	
De	ecember 2010 reveale	ed "Lorteb 5	- 1				J	
(A	cetaminophen-Hydrod	codone) 5-500 milligram	!				i	
tai	blet Enteral Tube-as n	eeded (PRN): one every	i			f	j	
10	hours as needed Pain	•••					·	
Me	edical record review of	the Medication	1			}	1	
		MAR) for November 2010	Ì			[]	
гev	realed a total of sever	nteen administrations of	ĺ			1	}	
the	PRN Hydrocodone-A	cetaminophen, Review				}		
oft	the December 2010 M	AR revealed a total of						
	teen administrations o		- 1				1	
Hyc	drocodone-Acetemino	ohen.	- 1			1	ľ	

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 12/20/2010 FORM APPROVED

STATEME	NT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	CY21 MI	U TIDLE COMPANIES		OMR NO. 0938-039-	
		IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A BUILDING		(X3) DATE SURVEY COMPLETED	
NAME OF	PROMPET OF THE PARTY.	445319	B. WING		12/16/2010		
i .	PROVIDER OR SUPPLIER NS AT WINCHESTER (CARE & REHABILITATION CENT	TER	STREET ADDRESS, CITY, STATE, ZIP CO 32 MEMORIAL DRIVE WINCHESTER, TN 37398			
(X4) ID PREFIX TAG	/ (EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	PROVIDER'S PLAN OF COR.	CUMITA BE	(X5) COMPLETION DATE	
F 514	Continued From pag	ge 15	F 514	1			
I I I I I I I I I I I I I I I I I I I	Record for November Hydrocodone-Acetar twenty-four administration December 2010 Conference of the PRN Hydrocodon Medical record review Flow Sheet for November 2010 Record and Pain Indication documenting Record and Pain Id not match so that the courate or complete. The sheet of the nurses were to documentionally of the nurses were to d	minophen revealed a total of rations. Review of the ntrolled Drug Record eventeen administrations of the Pain Management of the Pain Management ention of the PRN ention of the PRN ention of the PRN ention of the PRN on on the MAR, Controlled Management Flow Sheet he medical record was not Further interview revealed eument on the MAR, d and the Pain eet every time a PRN pain stered and the facility					
ad wit Dis Ac Ch Ab	mitted to the facility on the diagnoses including sease, Diabetes Melliteident with Left Hemiliteria Obstructive Pulicove Knee Amputation flux Disease, Periphe	tus, Cerebrovascular paresis, Hypertension, monary Disease, Right I, Gastroesophageal					

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (DENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DAT	(X3) DATE SURVEY COMPLETED			
	445319		445319	B. WING		-		
NAME OF PROVIDER OR SUPPLIER WILLOWS AT WINCHESTER CARE & REHABILITATION CENT					STREET ADDRESS, CITY, STATE, ZIP CODE			
<u> </u>	(X4) ID PREFIX TAG	TX (EACH DEFICIENCY MUST BE PRECEDED BY FULL		ID PREFIX TAG	PROVIDER'S PLAN OF	TON SHOULD BE THE APPROPRIATE	COMPLETION DATE	
	R N d N R N d N R N d N R R N d N R R N d N R R R N d N R R R N d N R R R N N O M S N d N R R N N O M S N R R N N O M S N R R N N N N N N N N N N N N N N N N	dated September 21, (Acetaminophen-Hyd milligrams) orally. Malevery 6 hours) PRN in Review of the Control lovember 2010, reve eventy-five doses of lovember. eview of the Medical ovember revealed nurses of Lortab adminipovember. eview of the Pain Maleveiew with the Direct revealed only on atment documented. Enview with the Direct cember 16, 2010, at signification Administration es of Lortab on the Pain Maleveiew of the Consultant ember 22, 2010, revealed in Medication Administration and the Pain Maleveiew of the Consultant ember 22, 2010, revealed in Medication Administration and the Pain Maleveiew of the Consultant ember 22, 2010, revealed in Medication Administration and the Pain Medication Ad	evealed a physician's order 2010, which stated "Lortab rocodone) 7.5/500 mg ay have 1 tab (tablet) Q6 hrs (as needed). Ided Drug Record for aled nurses signed out Lortab during the month of Lortab during the month of istered during the month of magement Flow Sheet mented five doses of Lortab or month of November. Pain Management Flow one occasion, November was the effectiveness of cor of Nursing on 2:30 a.m., in the med the nurses failed to es of Lortab on the in Record and seventy ain Management Flow. Pharmacy Report dated ealed a comment of istration Record)	F 51				

PAGE 21/27 12/30/2010 16:40 19319624224 WILLOWS DEPARTMENT OF HEALTH AND HUMAN SERVICES PRINTED: 12/20/2010 CENTERS FOR MEDICARE & MEDICAID SERVICES FORM APPROVED STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION OMB NO. 0938-0391 (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION IDENTIFICATION NUMBER: (X3) DATE SURVEY A. BUILDING COMPLETED B. WING 445319 NAME OF PROVIDER OR SUPPLIER 12/16/2010 STREET ADDRESS, CITY, STATE, ZIP CODE WILLOWS AT WINCHESTER CARE & REHABILITATION CENTER 32 MEMORIAL DRIVE WINCHESTER, TN 37398 SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL (X4) ID PREFIX TAG PROVIDER'S PLAN OF CORRECTION
(EACH CORRECTIVE ACTION SHOULD BE
CROSS-REFERENCED TO THE APPROPRIATE ID PREFIX (X5) COMPLETION DATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG DEFICIENCY) F 514 Continued From page 17 F 514 medications were accounted for.

CMS-2567(02-99) Provious Versions Obsolete

Event ID: WMWW11

Facility ID: TN2603

If continuation sheet Page 18 of 18